

ADOLESCENT SEXUAL HEALTH

Managing the very young patient: a conflict between the requirements of the Children Act and the VD regulations?

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We describe the case of a 12 year old girl who presented requesting screening for sexually transmitted infections and discuss a conflict between concerns of clinicians to maintain confidentiality and concerns of social workers to investigate the possibility of sexual abuse.

The sexual health of young people has been of concern for some years since it became apparent that the burden of sexually transmitted infections (STI) and unintended pregnancy fell disproportionately on the very young. Since the Fraser ruling in the Gillick case¹ it has been possible for doctors and nurses to offer contraceptive and other sexual health services to young people under the age of 16 provided that the clinician believes this is in the young person's interest and the young person understands the consultation. The clinician should encourage the involvement of someone with parental authority. Thus, it has been possible to see young people in sexual health clinics and many services have been proactive in encouraging young people to attend. Despite changes in sexual behaviour such that 26% of girls and 30% of boys are sexually active before the age of 16,² sexual intercourse with a girl under the age of 16 remains illegal and particular concern attaches to intercourse before the age of 13 when it is not possible for a man to claim in defence that he was unaware of the girl's age.

The central tenet of the Children Act³ is that the best interests of the child are paramount. Some child protection teams interpret this as a requirement to refer to them for assessment any child under the age of 16 who is known to have had sexual intercourse. Adoption of such a policy in a sexual health setting would be in direct conflict with the intent of the Fraser ruling and would discourage young people from attending sexual health services, which would not be in their best interests nor in the interest of the wider community.

In Watford, we have been running a multipurpose service for young people since 1994. The service, "Awareness," takes place once a week in the department of genitourinary medicine and offers a full genitourinary medicine (GUM) and family planning service to young people under the age of 20. The department also has had an outreach worker for young people who has been active in schools and social settings encouraging attendance. Confidentiality has been the cornerstone of the service and efforts have been concentrated in some of the more socially deprived areas to encourage confidence in the service.

In a previous case of a young girl who had attended the clinic and whose death was subsequently the subject of a Part 8 Enquiry under the terms of the Children Act,⁴ issues were raised about the conflict between the need to maintain confidentiality and the need to share information, as envisaged by the Children Act. The Draft National Guideline on the Management of Suspected Sexually Transmitted Infections in Children and Young People⁵ draws attention to this conflict

and to the need to involve the young person in all stages of the process. We present a case where the clinicians concerned were anxious to protect the confidentiality of a young patient despite pressure to share information from social services.

CASE REPORT

A 12 year old girl (Ms S) presented to a routine open access GUM clinic requesting a screen for STI. She was accompanied by an older girl (Ms T), who was known to the department as she had accompanied other young girls previously. The history was that Ms S had got drunk at a party 2 weeks previously and thought that she had had penetrative vaginal intercourse with a man known to her, aged 21. She had had only one menstrual period, a month previously.

The initial consultation was with an experienced clinic doctor who assessed her to be Fraser/Gillick competent. Ms S agreed to an examination and the doctor noted that the external genitalia were immature and that there was slight bruising of the vulva at 4 o'clock. Ms S declined a speculum examination and it was very difficult to ascertain whether the hymen was intact. Swabs for *Neisseria gonorrhoeae* and *Chlamydia trachomatis* were taken from the urethra and a blind vaginal swab for *N gonorrhoeae*. The results of these tests were reported as negative. A pregnancy test was also negative.

The doctor was concerned about Ms S's risk taking behaviour and referred her to the health adviser who ascertained that Ms S frequently drank to excess but had not had any previous sexual experiences. Her parents, with whom she lived, were described as "strict" and she said that they were not aware of her behaviour. She declined to give any details of the 21 year old man concerned although she did say that he was aware of her age. The health adviser assessed her to be emotionally immature and to have a poor knowledge of pregnancy and infection risks. She discussed these issues with her. Ms S and Ms T then asked if the consultation would be confidential and the health adviser replied that she was concerned about Ms S's age and that she would need to consult colleagues within the department about the most appropriate next step. She asked Ms S to reflect on her behaviour and to return after one week to collect her results and for a further discussion. She said that she would maintain the girl's confidentiality for 7 days while she sought advice, on the condition that Ms S returned as agreed.

The health adviser (AA) subsequently discussed the case with the clinic consultant (PEM), the doctor concerned (EAB) and then posed a "what if" question to the department's social worker. The social worker was concerned about Ms S's vulnerability, her alcohol abuse, the significant age differential between her and the 21 year old and therefore the probable exploitative nature of the relationship. Engaging his department's statutory responsibility to make inquiries into Ms S's welfare he requested her name in order to look her up on the Child Protection Register. When this was declined, because of the promise of confidentiality, a social work manager and the trust's child protection nurse intervened and also demanded the name of the girl immediately.

A decision was made by the department's clinicians that they would try to involve the girl herself in the decision to refer to the children, schools, and family team and therefore they declined further information until after the girl had been seen the following week. However, Ms S defaulted from the follow up appointment and her name was given to the social worker as it was felt that her vulnerability allowed this breach of confidentiality. An investigation was initiated and a strategy meeting was held with the police and members of the social services department. Subsequently, it transpired that the accompanying girl (Ms T), who worked in the voluntary sector with homeless young people, was a sexual partner of the man involved and was believed to be involved in the procurement of young girls.

DISCUSSION

The teenage pregnancy strategy⁶ and the draft sexual health strategy⁷ express the view that services for young people are to be supported and developed. Confidence in a service for young people is hard won and easily lost. Genitourinary physicians believe that the NHS Venereal Diseases Regulations⁸ protect their patients from unwanted disclosure and thus encourage attendances at services for young people. Genitourinary physicians further believe that such strict confidentiality does not exist in other sectors and a breach of confidentiality is thus a very significant issue. The primary aim of the Children Act is to encourage child focused services and it requires services to work together to share information. It is predicated on the belief that previous child abuse tragedies were avoidable if all agencies shared appropriate information. This provides a difficulty for clinicians who see many young people between 13 and 16 who are having consensual sexual intercourse with their peers. For clinicians who are unfamiliar with the child's background, it is difficult to identify which of these young people may be being abused and who require onward referral within the terms of the Children Act. Indeed, clinicians can only utilise information which is given by the client and are therefore at risk of being deceived, particularly if the young person wishes to conceal something. Furthermore, detailed questioning might deter some young people needing help, without protecting those who are at risk, but unwilling to disclose. Frequent referral would clearly destroy the credibility of the service as far as the target population were concerned. Failure to refer may lead to tragic consequences.

We feel that it is important for the Department of Health to signal an understanding of these difficulties by explicitly offering guidance to trusts and health authorities about the

need to maintain confidentiality of young people while being aware of the need to identify those at risk of abuse. Additional training of clinicians and child protection teams would also be valuable.

The issues for under 13 year olds are different as the law does not recognise consensual intercourse at this age. In the case in question, it was not clear whether penetrative intercourse had taken place, and the clinicians felt that it was not appropriate to involve the legal system before there had been an opportunity to explore issues raised by the case in more detail. Eventually, however, the alleged assailant was prosecuted by the police and pleaded guilty.

The relationship between the accompanying person and the index case was initially thought to be that of an older friend supporting a new patient through her first attendance. Indeed, the older girl had previously brought young patients to the clinic in her role as a support worker in the voluntary sector. When the case was investigated by social services and the police, this worker was found to be a sexual partner of the accused man and was suspected of procuring young girls. This raises the issue of vetting voluntary workers and supervising their work. Even with such procedures, however, it is unlikely that the relationship between the abuser and the worker would have been identified.

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REFERENCES

- 1 Gillick v West Norfolk and Wisbech AHA, 1986.
- 2 Wellings K, Nanchahal K, MacDowall W, *et al.* Sexual behaviour in Britain: early heterosexual experience. *Lancet* 2001;**358**:1843–50.
- 3 Children Act 1989.
- 4 Harrow Area Child Protection Committee. Confidential Report 1999.
- 5 Clinical Effectiveness Group. Draft National Guideline on the Management of Suspected Sexually transmitted Infections in Children and Young People. www.mssvd.org.uk/CEG/ceguidelines.htm
- 6 Social Exclusion Unit. *Teenage pregnancy*. London: Stationery Office, 1999.
- 7 Department of Health. *The national strategy for sexual health and HIV*. London: DoH, 2001.
- 8 National Health Service, England and Wales. *The National Health Service (Venereal Diseases) Regulations 1974*. Statutory Instruments 1974 No 29. London: HMSO, 1974.